CHAPTER 11 ADDENDUM A

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FIGURE 11-A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (AT-RISK FUNDS INVOLVED) **NOTE:** Use of this letter is not mandatory. (Addressee) (Address) (City, State, ZIP) DATE: (Enter date mailed.) SSN: (If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter SSN, if known. Leave blank if debtor's SSN is not available.) PRINCIPAL: ICN: Dear (Use first paragraph only if the recipient has advised the contractor of an

Overpayment.) Thank you for your recent notification that this office made an erroneous payment on claims in your **(Or Beneficiary's Name)** behalf. We appreciate your cooperation in bringing this matter to our attention. **(If the first paragraph is not applicable, use the following introductory paragraph to the letter;)** The purpose of this letter is to inform you that an overpayment may have been made to you. We are required to provide you with the following information:

On (Date of Check) we sent you a check in the amount of \$_____ for services furnished to you (or Beneficiary's Name if he/she is under 18 years of age and the letter is being sent to the sponsor/parent/guardian) by (Name and Address of Provider) on (Dates of Care). This was for (Type of Service). However, that check represents an overpayment of \$_____.

(Insert a paragraph which provides a clear and complete explanation of how the overpayment arose, how the overpayment was calculated, why it was not correct, and how the error was discovered.) (If the payment arose as a result of contractor error, the contractor will add the following sentence at the end of the explanation.) We truly regret any inconvenience this error may have caused you, and we will make every effort to prevent such errors from happening in the future.

FIGURE 11-A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (AT-RISK FUNDS INVOLVED) (CONTINUED)

(Continued from overpayment explanation above.) Since our records indicate that an overpayment was made, we are required to collect funds which were mistakenly issued from our accounts. We are also required to collect interest on all delinquent debts. Interest shall begin to accrue not earlier than 30 days following notice of the overpayment. The interest rate being assessed is _____% (Enter the rate which would be collected under the Federal Claims Collections Act or the rate allowed by state law, whichever is lower.) Accrued interest will be waived if this debt is paid in full within 30 days from the date of this letter. If payment is not made within 30 days, interest will accrue from the date of this letter.

(If administrative costs will be assessed for expenses in collection of the debt the debtor must be advised of these charges. Assessment of these charges must be approved by the TRICARE Management Activity (TMA)).

We are required to annotate your records to enable us to collect an erroneous payment by offset against current or future TRICARE claims. However, no such offset action will be taken for thirty days from the date of this letter. Since the possibility of offset against your TRICARE claim exists, we are also required to provide the following information to you.

You have the right to inspect and copy all records pertaining to this debt. If you believe this determination regarding your TRICARE coverage is incorrect or dispute the amount of the debt as calculated above, you have a right to request an administrative review of the indebtedness.

If the recoupment action is being initiated as part of a decision rendered by the TRICARE appeals and hearings process, do not include the next two sentences. For the purposes of this recoupment action, your right to an administrative review includes your right to a "Reconsideration" under the regulation which governs TRICARE appeals (32 CFR 199.10). If you request an administrative review, you will be advised if you have further appeal rights to TMA.

If you request an administrative review, it must be in writing and be received by this office within 90 days from the date of this letter. Your request should state specific reasons why you believe you do not owe this debt. You should also attach any supporting documentation, such as bookkeeping and medical records, and a copy of this letter.

If you need to request a waiver of this debt based upon an inability to pay, you will be required to complete a financial affidavit. If it then appears that you are financially unable to make a full refund at this time, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Please note, however, that any payment plan will include an interest charge at the rate specified above.

Please make your payment, for the total amount shown above, within 30 days in order to preclude interest and late charges from accruing. Send your check or money order, payable to TRICARE, to (Name Of Contractor) in the enclosed self-addressed envelope. However, if you do not believe you owe this debt, please contact us immediately with a request for an administrative review and include all supporting documentation.

FIGURE 11-A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (AT-RISK FUNDS INVOLVED) (CONTINUED)

Your cooperation and prompt attention to this matter are very much appreciated.

Sincerely,

(Signature) (Title)

Enclosure: Self-addressed envelope

ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE FIGURE 11-A-2 THIRD PARTY LIABILITY"

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY CHAMPUS / CHAMPVA

Form Approved OMB No. 0720-0003 Expires Jan 31, 1994

IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:

- (1) THE CHAMPUS CLAIMS PROCESSOR WHO SENT YOU THE FORM; OR
- (2) THE CHAMPUS CLAIMS PROCESSOR FOR THE STATE/COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).

Public reporting burden for this collection of information is estimated to average 57 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other isspect of this collection of information including subgestions for reducing this burden, to Department of Defense, Walnich Headquarters Services, Discretorate for information Devastions and Reports, 1215 Jefferson Davis Highway, Suite 1294, Arlington, VA. 22202-4302, and to the Office of Management and Budget. Paperwork Reduction Project (0704-0090), Washington, DC. 20503.

PRIVACY ACT STATEMENT

AUTHORITY:

42 U.S.C. 2651 - 2653; 10 U.S.C. 1079, 1085, 1086 and 1092; E.O. 9397; 38 U.S.C. 613.

PRINCIPAL PURPOSE(5): To assist in determining possible third party liability for medical supplies and services claims under CHAMPUS/CHAMPVA Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

ROUTINE USE(S):

Information may be given to the Department of Veterans Affairs, the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collections agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS

DISCLOSURE:

Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim

INSTRUCTIONS

According to information submitted with your recent CHAMPUS or CHAMPVA claim, you were treated for an injury of some kind. Because the CHAMPUS claim form does not include information about how you were injured, we are asking that you also complete this form. The Federal Medical Recovery Act, 42 U.S.C. 2651-2653, allows the Government to be reimbursed for its costs of treating you, if you were injured in an accident caused by someone else. The Government can often recover its costs from (1) the person who caused the accident or that person's insurance company; or (2) the owner of the property where the accident occurred or the owner's insurance company. The Government also may be able to recover its costs from (1) any insurance company which insures your family for hospital and medical expenses; or (2) your employer's Worker's Compensation or other insurance, if you were injured at work.

If you were not treated for an injury, please describe the circumstances of your treatment in the Remarks section on Page 1. If you do not believe that someone else caused your injury, please describe in detail the circumstances surrounding your injury in the Remarks section on Page 1. If you use the Remarks section for either of these purposes you do not need to complete the rest of the form. However, be sure to sign and return it according to the other instructions you have received.

This form is to be completed by persons who have received medical care at Government expense or by a responsible family member. In cases of young children, this form should be completed by a parent or guardian.

Answer all questions in as much detail as possible. The information you provide may be of great help to the Government and to you in recovering from the person who caused your injuries. We suggest you retain a copy of this form for your own use.

The words "None," "NA," and "Unknown" should be inserted where appropriate

Attach additional sheets where necessary to provide complete information.

Complete all items to the best of your knowledge, BE SURE TO SIGN AND DATE THE FORM ON PAGE 5, RETURN IT WITHIN 1D DAYS.

IMPORTANT

This information is requested solely for the purpose of processing your CHAMPUS relmbursement claim, it has no bearing on any legal action you may pursue as a result of your injury. All questions you may have regarding possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury daim you may have without notice to a military claims officer.

DD Form 2527, NOV 91

Previous editions are obsolete

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FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY" (CONTINUED)

STATEMENT OF PERS		Y - P		LE TI	HIRD PARTY LIA	BILITY	
SECTION I - GENERAL INFORMATION							
SPONSOR SPONSOR'S NAME (Last, First, Middle Initial)					b. SSN		
2. INJURED BENEFICIARY					· · · · · · · · · · · · · · · · · · ·		
a. INJURED BENEFICIARY'S NAME (Last, First,	b. AGE	c. R		HIP TO	SPONSOR (X one)		
Middle Initial)			SELF SPOUSE	1	NATURAL/ADOPTED CH FORMER SPOUSE		STEPCHILD OTHER
d. HOME ADDRESS (Street, Apartment Number, City, State, ZIP Code)					RESS (If different from inj t Number, City, State, Zi		iciary's)
TELEPHONE NO. (Include Area Code)		TELI	EPHONE N	0. (Inc	lude Area Code)		
SECTION II - REMARKS 3. USE THIS SECTION TO DESCRIBE IN YOUR O	WN WORDS HOW	YOU V	WERE INJU	IRED.			
SECTION III - NON-VEHICULAR ACCIDENTS Complete if injuries did not result from a moto	r vehicle accident.	lf inju	ıries resul	ted fro	m a vehicular accident,	go to Sect	ion IV.
4. LOCATION							
a. SITE OF INJURY (Street/Place, City, County, S	tate)	b. 1	TIME (Hou	r)	A.M. P.M.	(YYMMDD)	
d. NAME AND ADDRESS OF OWNER OF PROPE	RTY WHERE INJURY	r occ	URRED		e. NAME OF OCCUPA different from Owl		PERTY (if
5. PERSONS INVOLVED							
a. NAME (Last, First, Middle Initial)	b. ADDRESS (Str	eet, C	ity, State, i	ZIP Cod	e) AND TELEPHONE NO.	. (Include A	rea Code)
DD FORM 2527, OCT 94						Pa	ge 2 of 4 Page

FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY" (CONTINUED)

SECTION III - NON-VEHICULAR AC	CIDENTS (Co.	ntinued)						
6. WITNESSES								
a. NAME (Last, First, Middle Initia	al)	b. ADDRES	S (Street, City, Stat	te, ZIP Cod	de) AND TE	ELEPHONE NO. (include Area Code)	
-								
7. POLICE INVESTIGATION								
a. WAS AN INVESTIGATION CON (If Yes, state by whom (e.g.,City/ Police, Sheriff's Dept.) YES	DUCTED? State		YONE ARRESTED THE ACCIDENT? 'ge)			c. DISPOSITION Fine, Jail Ser	N OF CASE (e.g., Dismissal, itence)	
NO	ſ	NO						
e. WERE OTHER FAMILY MEMBEI (If Yes, give name(s) and relation		IN THE ACCI	DENT?					
NO								
f. WAS THE ACCIDENT WORK RE	LATED?			•				
(If Yes, state circumstances)								
YES NO								
8. INSURANCE								
a. INSURANCE COMPANY OF OWN PROPERTY WHERE INJURY OCCI (e.g., Homeowner's Insurance	JRRED	b. INSURAN WHO CA from Ite	ICE COMPANY OF LUSED ACCIDENT m a.)	PERSON (If differe	ent c. Y	OUR OWN INSUI	RANCE COMPANY	
(1) COMPANY NAME		(1) COMPAR	IY NAME		(1) C	(1) COMPANY NAME		
(2) ADDRESS (Include ZIP Code)		(2) ADDRES	SS (Include ZIP Code)		(2) A	(2) ADDRESS (Include ZIP Code)		
(3) POLICY NUMBER		(3) POLICY N	IUMBER		(3) P	(3) POLICY NUMBER		
(4) AMOUNTS AND TYPES OF COVERAGE (4) AMOUNTS AND TYPES OF COVERAGE (4) AMOUNTS AND TYPES OF COVER			YPES OF COVERAGE					
SECTION IV - VEHICULAR ACCIDENT Attach a copy of the official police report to this form.								
9. ADDITIONAL INFORMATION O								
a. INJURED BENEFICIARY'S AUTOMOBILE INSURANCE COMPANY'S ADDRESS (Include ZIP Code) COMPANY					Code)			
c. INSURANCE COMPANY TELEPHONE NO. (Include Area Code)								
d. POLICY NUMBER	e. AMOUN	TS AND TYP	E OF COVERAGE					
	(1) LIABILITY S	Υ	(2) MEDICAL PA	/MENT ((3) UNINSU S	RED MOTORIST	(4) NO FAULT S	

FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY" (CONTINUED)

SECTION IV - VEHICULAR ACCIDENT (CO	antinued)					•		
9.f. WAS ACCIDENT REPORTED TO YO		COMPANY?		g. HAS YO	UR INSURAN	CE COMPAN	Y ASSIGN	ED A
(If No, explain)				CLAIM C	R FILE NUM	BER? (If Yes,	provide n	umber)
YES				YES				
NO				NO				
h. WAS ACCIDENT WORK RELATED?	(If Yes, state circ	umstances)		•				
YES								
NO								
CECTION V. MISCELLANEOUS								
SECTION V-MISCELLANEOUS 10. GOVERNMENT HOSPITALIZATION								
If you were hospitalized or expect	to be hospitalize	ed in a govern	ment hospita	i, complete 1	the following	g:	d. IS TRI	AT-
a. NAME OF HOSPITAL	b. ADDRESS (In	clude ZIP Code)			c. DATES HO	SPITALIZED	MENT PLETED?	(X one)
					FROM	то	YES	NO
						L		
						ļ		
						<u> </u>		
11. YOUR ATTORNEY								
a. ATTORNEY'S NAME		b. ADDRESS (Street, City, 1	State, ZIP Co	de)			
c. TELEPHONE NO. (Include Area Code	,							
C. TEEEFRONE NO. (MCIOGE ATES COOK	7							
12. RELEASE STATEMENTS		-						
a. HAVE YOU FURNISHED ANYONE O'	THER THAN THE	POLICE A	b. HAVE Y	OU SIGNED /	ANY RELEAS	E OR WAIVE	R OF RIGH	ITS?
STATEMENT AS TO WHAT HAPPENE	D? (If Yes, to w	hom was it	(If Yes,	to whom wa	s it given?)			
given?)			İ					
YES			YES					
NO			NO					
c. HAVE YOU RECEIVED ANY OFFER O	C CETTI FASENT	OR VOUR	A HAVE V	OU ACCEPTE	D ANY CETT	LEMENT? (If	Vac from	whom
INJURY? (If Yes, from whom?)	T SEIJLEMIENI I	-UK TOUK		v much?)	P WIS 2511	FFIAIEI41; (11	es, mon	WINDIN
YES			YES					
NO			NO					İ
SECTION VI-CERTIFICATION								
13. I have completed this form	and state the	at the inform	nation is t	rue to the	best of r	ny knowle	dge and	4
belief. Federal Laws (18 US								
making any false, fictitious,								
any department or agency				-				
- YOUR SIGNATURE					h Date c	GNED (YYMI	400)	
a. YOUR SIGNATURE					D. DAIE SI	GNED (TTMI	(טטוי)	
					i			
DD FORM 2527 OCT 94				·	<u>. </u>		0000 1 0	4 Pages

FIGURE	11-A-3	FIABILITY &	JESTIONNAIRE II	RANSMIIIAL LEITER	
Note:	To be da	ted same day	y as mailed.		
				SPONSOR SSN _ CLAIM # PROVIDER	
Dear			:		

We recently received a claim from you or your medical care provider for medical services required by (you/your dependent) which reflected a diagnosis code between 800 and 999. The diagnosis codes are utilized by medical providers, insurance companies, and medical benefit programs, such as TRICARE and Medicare, to reflect the nature of a patient's illness or injury. Diagnosis codes between 800 and 999 often, but not always, indicate that the patient suffered an accidental injury or illness. Because of the diagnosis code or codes on your claim form, we must ask you to complete the enclosed DD Form 2527 (Statement of Personal Injury--Possible Third Party Liability).

If someone else caused the illness or injury of you or your dependent, the government has the right to recover the money spent for medical care from that person or that person's insurer. The information you provide on the DD Form 2527 will not affect your legal rights in any personal claim or action you may have against the person who caused your injury. However, you should not furnish that person or his or her insurance company any information that might adversely affect your claim. Also, you should not sign any releases or agree to any settlement with that person or his or her insurance company without first discussing the case with a Uniformed Services Legal Officer or your own attorney.

The enclosed form must be completed by the TRICARE beneficiary, or your representative, even if your medical provider accepts TRICARE assignment and files the TRICARE claim for you. We encourage civilian medical providers to obtain a completed DD Form 2527 from the patient so that it can be submitted with the TRICARE claim form. However, if a claim has been submitted without the required DD Form 2527, the completed DD Form 2527 will be required before the claim is processed.

Remember, if you have other health coverage, including medical coverage obtained through a homeowner's insurance policy, your employment, student insurance, workers' compensation, personal injury protection or medical coverage through a no-fault, uninsured, or underinsured motorist clause of an automobile insurance policy, TRICARE cannot pay your claims until the other insurer has issued its payment toward your medical bills. The other insurer must also be listed on your TRICARE claim. A copy of the Explanation of Benefits from your other insurance company must be sent in with your TRICARE claim. If your claim is denied by the primary insurer, you must provide proof of the denial with your TRICARE claim. Any attempt to conceal the existence of other insurance that is primary to TRICARE constitutes fraud and may subject you to civil or criminal penalties. All insurance is primary to TRICARE except Medicaid and insurance which is specifically designed to supplement TRICARE benefits.

FIGURE 11-A-3 LIABILITY QUESTIONNAIRE TRANSMITTAL LETTER (CONTINUED)

Your claims for medical care will be held in a suspense status pending the completion and return of the enclosed DD Form 2527. To expedite the processing of your claim, please return the completed form with this letter within 10 days in the enclosed, self-addressed envelope. Please follow the instructions on the form carefully. If you were injured in an automobile accident, you may attach a copy of the police report in lieu of completing the section of the form entitled Vehicular Accidents. If any question on the form does not apply to you, please indicate that fact by placing an "N/A" in the appropriate block. Please utilize the block which invites you to describe in your own words how you were injured. Do not forget to sign the form. Forms that have not been fully completed and signed will be returned to you, and your suspended claims will be denied.

If the enclosed forms are not completed and returned within 35 days from the date of this letter, your claim and any related claims that have been suspended or are subsequently received will be denied. If you have already submitted a DD Form 2527 for the same accident, notify this office immediately. Even if your illness or injury was not caused by someone else, your TRICARE claims will not be processed until you return the completed and signed DD Form 2527. The information you provided on the DD Form 2527 will not affect payment of benefits on your TRICARE claim.

If you have any questions regarding the form, please contact the Health Benefits Advisor or Judge Advocate General (JAG) at the nearest military hospital. Thank you for your cooperation.

Sincerely,

(Signature) (Title)

Enclosures: DD Form 2527 Self-addressed envelope

FIGURE 11-A-4 TRANSMITTAL LETTER TO GOVER	NMENT CLAIMS OFFICER
REFERENCE: Beneficia Sponsor: Sponsor'	
Dear Sir or Madam:	
Enclosed is a DD Form 2527, completed by possible third party liability recovery under the enclosed are Explanations of Benefits represent medical care provided the beneficiary.	
respect to third party liability. Should you det	be provided upon your request. Please contact
S	incerely,
·	Signature) Title)
Enclosures:	
(EOBs) (DD Form 2527)	
(~~	

FIGURE 11-A-5 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TRICARE Management Activity (TMA).

(<u>Addressee</u>)		
(Address)		
(City, State, ZIP)		
	DATE: SSN:	(Enter date mailed.) (If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter SSN, if known. Leave blank if debtor's SSN is not available.)
	PRINCIPAL:	
	ICN:	
Dear:		
(Use first paragraph only if the recipe overpayment.) Thank you for your recent payment on claims in your (or Beneficiar in bringing this matter to our attention. (I following as the introductory paragraph you that an overpayment may have been with the following information:	notification that y's Name) behal f the first paragi to the letter.) Th	t this office made an erroneous f. We appreciate your cooperation raph is not applicable, use the e purpose of this letter is to inform
On (Date of Check) we sent you a chefurnished you (or Beneficiary's Name if l		

(Insert a paragraph which provides a clear and complete explanation of how the overpayment arose, how the overpayment was calculated, why it was not correct, and how the error was discovered. If the payment arose as a result of a contractor error, the contractor will add the following sentence at the end of the explanation.) We truly regret any inconvenience that this error may have caused you, and we will make every effort to prevent such errors from happening in the future.

being sent to the sponsor/parent/guardian) by (Name and Address of Provider) on (Dates of Care). This was for (Type of Service). However, that check represents an overpayment of

Since our records indicate that overpayment was made, we must formally advise you of the applicable laws governing the recoupment funds. Specifically, the Federal Claims Collection Act, beginning at 31 U.S.C. 3701, requires that federal agencies, including TMA, collect government funds which were mistakenly issued from their accounts. Further, government agencies are required to collect interest on all delinquent debts at the rate of (Enter the Rate of the Current Value of Funds to the United States Treasury) percent per year. Interest charges will be waived if this debt is paid in full within 30 days from the date of this letter. If payment is not made within 30 days, interest will accrue from the date of this letter.

FIGURE 11-A-5 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

(Continued from overpayment explanation above.) Additionally, federal agencies are required to assess a penalty charge, not to exceed six percent per year, upon any portion of the amount you owe that is outstanding for more than 90 days, as well as administrative costs, based upon the costs incurred in processing and handling the case.

Finally, we are required to annotate your records to enable us to collect an erroneous payment by administrative offset against current or future TRICARE claims. However, no such offset action will be taken for 30 days from the date of this letter. Since the possibility of offset against your TRICARE claim exists, we are also required to provide the following information to you.

You have the right to inspect and copy all records pertaining to this debt. If you believe this determination regarding your TRICARE coverage is incorrect or dispute the amount of the debt as calculated above, you have a right to request an administrative review of the indebtedness.

(If this recoupment action is being initiated as a result of a decision rendered from the TRICARE appeals and hearings process, do not include the next two sentences.) For the purposes of this recoupment action, your right to an administrative review includes your right to a "Reconsideration" under the regulation which governs TRICARE appeals (32 CFR 199.10). If you request an administrative review, you will be advised if you have further appeal rights to TMA.

If you request an administrative review, it must be in writing and be received by this office within 90 days from the date of this letter. Your request should state specific reasons why you believe you do not owe this debt.. You should also attach any supporting documentation, such as bookkeeping and medical records, and a copy of this letter.

If you need to request a waiver of this debt based upon an inability to pay, you will be required to complete a financial affidavit. If it then appears that you are financially unable to make a full refund at this time, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Please note, however, that any payment plan will include an interest charge at the rate specified above.

Please make your payment, for the total amount shown above, within 30 days in order to preclude interest and late charges from accruing. Send your check or money order, payable to TRICARE, to (Name of the Contractor) in the enclosed self-addressed envelope. However, if you do not believe you owe this debt, please contact us immediately with a request for an administrative review and include all supporting documentation.

Your cooperation and prompt attention to this matter are very much appreciated.

Sincerely,

(Signature)
(Title)

Enclosure:
Self-addressed envelope

FIGURE 11-A-6 SAMPLE LETTER TO PROVIDER REGARDING OVERPAYMENT (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

(Addressee)		
(Address)		
(City, State, ZIP)		
	DATE: SSN:	(Enter date mailed.) (Enter provider's taxpayer
		identification number, if known. If unknown leave blank.)
	PRINCIPAL:	•
	ICN:	
Dear:		
(Use first paragraph only if the recipoverpayment.) Thank you for your recen		
payment on claims in your (or beneficiar bringing this matter to our attention. The	y's name) behalf. '	We appreciate your cooperation in

following information:

On (Date of Check) we sent you a check in the amount of \$_____ to cover services you furnished (Beneficiary's Name) on (Dates of Care). This was for (Type of Service). However, that check represents an overpayment of \$_____.

(This paragraph must provide a clear and complete explanation of how the overpayment arose, how the overpayment was calculated, why it was not correct, and how the error was discovered.) At the end of the explanation, the Contractor will add the following sentence: We regret any inconvenience that this error may have caused.

The Federal Claims Collection Act, beginning at 31 U.S.C. 3701, requires that federal agencies, including TMA, collect government funds which were mistakenly issued from their accounts. Further, government agencies are required to collect interest on all delinquent debts at the rate of (Enter the Rate of the Current Value of Funds to the United States Treasury) percent per year. Interest charges will be waived if this debt is paid in full within 30 days from the date of this letter. If payment is not made within 30 days, interest will accrue from the date of this letter. If the claim(s) on which this recoupment action is based was assigned to a participating provider, both the provider and the TRICARE beneficiary have the right to appeal this determination. If the claim(s) was not assigned, only the beneficiary may appeal this determination.

Additionally, federal agencies are required to assess a penalty charge, not to exceed 6% per year, upon any portion of the amount you owe that is delinquent for more than 90 days, and administrative costs, based upon the costs incurred in processing and handling the case because it became delinquent.

FIGURE 11-A-6 SAMPLE LETTER TO PROVIDER REGARDING OVERPAYMENT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

Finally, we are required to annotate your records to enable us to collect the erroneous payment by administrative offset against future TRICARE claims. No such offset action will be taken for 60 days from the date of this letter, however. Since the possibility of offset against your TRICARE claim exists, we are required to provide the following information to you.

You have the right to inspect and copy all records pertaining to this debt. If you believe this determination regarding your TRICARE coverage is incorrect or dispute the amount of the debt as calculated herein, you have a right to request an administrative review of the indebtedness.

NOTE: If this recoupment action is being initiated as a result of a decision rendered during the appeals process, do not include the last two sentences of this paragraph.

For the purposes of this recoupment action, your right to an administrative review includes your right to a Reconsideration under the regulation which govern TRICARE appeals (32 CFR 199.10). If you request an administrative review, you will be advised if you have further appeal rights to TMA.

Your request must be in writing and must be received by this office within 90 days from the date of this letter. Your request should state specific reasons for believing that you are not indebted for any amount listed herein, and should be accompanied by supporting documentation, such as bookkeeping and medical records, and a copy of this letter. If you wish to request a waiver based upon an inability to pay, you will be required to complete a financial affidavit. If it then appears that you are financially unable to make a full refund at this time, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Please note, however, that any payment plan will include an interest charge at the rate specified above.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to TRICARE, (name of the contractor) in the enclosed self-addressed envelope. If payment is not received within 30 days, interest and other late charges will accrue.

Your cooperation and prompt attention to this matter is very much appreciated.

Sincerely,

(Signature)
(Title)

Enclosure:
Self-addressed envelope

FIGURE 11-A-7 SAMPLE LETTER TO BENEFICIARY OR PROVIDER ADVISING OF OFFSET (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

NOTE: To be dated same day as mailed.

Dear (Name of provider or beneficiary) (sponsor, parent or guardian):

On **(Date)** we sent you a letter concerning an overpayment of \$______that was made on your claim for services provided to **(Name of Patient)** in which you were informed that if you did not refund that amount within 30 days (60 days if debtor is a provider) of the date of the letter, the overpayment would be withheld from any future claim payments.

If we do not receive the requested payment or a response to this letter, the following actions are required under our TRICARE contract and the Federal Claims Collection Act.

- **1.** Apply all payments of future claims to the overpayment until the amount is recouped.
- **2.** Refer the overpayment to Office of General Counsel, TMA for collection which will result in added administrative costs and fees as well as an adverse credit rating.

(Insert the following paragraph if the debtor has not previously been told of his right to appeal a denial based upon TRICARE eligibility or because a service or supply is not a TRICARE benefit. If the Contractor is uncertain whether appeal rights have previously been offered, the paragraph should be included.)

If you believe that this recoupment action is improper or incorrect, you have the right to request a reconsideration. Your written request, stating specific reasons why you feel the action taken is incorrect or improper, is to be attached to this letter and received within 90 days from the date on the enclosed original demand letter.

(Use the following additional paragraph if the debtor is a participating provider.) The offset taken against your claim has been applied toward your indebtedness to the U.S. Government and constitutes payment of the claim. You may not seek reimbursement for offset amounts from the TRICARE beneficiary for whom the services were provided.

Sincerely,

(Signature) (Title)

Enclosures: (self-addressed envelop) (initial demand letter)

FIGURE 11-A-8 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

(Addressee)		
(Address)		
(City, State, ZIP)		
	DATE:	(Enter date mailed.)
	SSN:	(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter debtor's SSN, if known. Leave blank if
		debtor's SSN is not available.)
	PRINCIPAL:	
	INTEREST:	(Enter interest on principal at current rate for 30 days.)
	TOTAL DUE:	5
Dear:		
On (Date) we wrote to you explaining check dated A copy of that initial letter, please read it carefully. It con	t letter is enclose	d. If you have not already read our

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

If you are unable to refund the full amount in one payment, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Any payment plan will include an interest charge of (Enter the rate of the current value of funds to the United States Treasury) percent per year.

(If debtor is not the sponsor, and debtor's Social Security Number is not otherwise available, add the following paragraph.)

FIGURE 11-A-8 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

You are requested to furnish your Social Security Number by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1982, Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your Social Security Number will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your Social Security Number is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to (TRICARE Contractor Name) in the enclosed self-addressed envelope.

Failure to respond to this second request will result in forced collection by administrative offset against any future claims filed by you.

onset against any ruture claims filed by you	l.
	Sincerely,
	(Signature) (Title)
Enclosures: Initial demand letter Self-addressed envelope	
	· ·
Social Security Number	Signature

FIGURE 11-A-9 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

(Addressee)		
(Address)		
(City, State, ZIP)		
	DATE:	(Enter date mailed.)
	SSN:	(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter debtor's SSN if known. Leave blank if debtor's SSN is not available.)
	PRINCIPAL:	
	INTEREST:	(Enter interest on principal at current rate for 30 days.)
	TOTAL DUE:	5
Dear:		
On (Date) we wrote to you expl check dated A copy of the initial letter, please read it carefully.	at letter is enclosed. If y	•

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

If you are unable to refund the full amount in one payment, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Any payment plan will include an interest charge of (enter the rate of the current value of funds to the United States Treasury) percent per year.

(If debtor is not the sponsor, and debtor's Social Security Number is not otherwise available, add the following paragraph.)

FIGURE 11-A-9 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

You are requested to furnish your Social Security Number by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1982, Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your Social Security Number will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your Social Security Number is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to (TRICARE Contractor Name) in the enclosed self-addressed envelope.

If we do not hear from you within 30 days, your file will be transferred to OCHAMPUS and involuntary collection action will be initiated. This may include administrative offset of other federal funds owed you or a referral to the Department of Justice for appropriate legal action

action.	
	Sincerely,
	(Signature) (Title)
Enclosures: Initial demand letter Self-addressed envelope	
	•
Social Security Number	Signature

FIGURE 11-A-10 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

(Addressee)		
(Address)		
(City, State, ZIP)		
	DATE: TIN:	(Enter date mailed.) (Enter provider's taxpayer identification number, if known. If unknown, leave blank.)
	PRINCIPAL:	
	INTEREST:	(Enter interest on principal at current rate for 30 days.)
	TOTAL DUE:	•
Dear:		
On (Date) we wrote to you explaining to check dated covering services you enclosed. If you have not already read our important information about your rights.	provided (Ben	eficiary). A copy of that letter is

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Taxpayer's Identification Number or Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

If you are unable to refund the full amount in one payment, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Any payment plan will include an interest charge of (enter the rate of the current value of funds to the United States Treasury) percent per year.

(If debtor is not the sponsor, and debtor's Taxpayer's Identification Number or Social Security Number is not otherwise available, add the following paragraph.)

FIGURE 11-A-10 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

You are requested to furnish your Taxpayer's Identification Number (TIN) or Social Security Number (SSN) by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1982, Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your SSN will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your SSN is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to (TRICARE Contractor Name) in the enclosed self-addressed envelope. If payment is not made within 30 days, interest and other late charges will continue to accrue. Failure to respond to this second request will result in forced collection by administrative offset against any future claims filed by you.

onset against any ratare claims mea by you	•
	Sincerely,
	(Signature) (Title)
Enclosure Initial demand letter Self-addressed envelope	
is unavailable. The paragraph above, which Identification Number or Social Security N	onsor, and the debtor's Social Security Number hexplains to the debtor how the Taxpayer's Jumber will be used, under what authority it is, must be included in the letter to the debtor.)
Taxpayer's Identification Number or Social Security Number	Signature

FIGURE 11-A-11 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

(Addressee)		
(Address)		
(City, State, ZIP)		
	DATE: TIN:	(Enter date mailed.) (Enter provider's taxpayer identification number, if known. If unknown, leave blank.)
	PRINCIPAL:	
	INTEREST:	(Enter interest on principal at current rate for 30 days.)
	TOTAL DUE:	
Dear:		
On (Date) we wrote to you explaining the check dated covering services you penclosed. If you have not already read our in important information about your rights.	provided (Bene	eficiary). A copy of that letter is

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Taxpayer's Identification Number or Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

(If debtor is not the sponsor, and debtor's Taxpayer's Identification Number or Social Security Number is not otherwise available, add the following paragraph.)

You are requested to furnish your Taxpayer's Identification Number (TIN) or Social Security Number (SSN) by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1990 Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your SSN will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your SSN is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

FIGURE 11-A-11 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to (TRICARE Contractor Name) in the enclosed self-addressed envelope. If payment is not made within 30 days, interest and other late charges will continue to accrue.

If we do not hear from you, your file will be transferred to the TRICARE Management Activity - Aurora and involuntary collection action will be initiated. This may include administrative offset of other Federal funds owed you or a referral to the Department of Justice for appropriate legal action.

Justice for appropriate legal action.	
	Sincerely,
	(Signature) (Title)
Enclosures: Self-addressed envelope) (Initial demand letter)	
Number or Social Security Number is uto the debtor how the Social Security N	sponsor, and the debtor's Taxpayer's Identification inavailable. The paragraph above, which explains (umber will be used, under what authority it is tary, must be included in the letter to the debtor.)
Taxpayer's Identification Number or	Signature

FIGURE 11-A-12 PROMISSORY NOTE IN REPAYMENT OF PRE-EXISTING DEBT (NOT-AT-RISK FUNDS INVOLVED)

1. Obligation - For value received, I (we, jointly and severally,) the maker(s), promise to
pay to the order of (Insert Name of Contractor), the principal sum of dollars,
with interest accruing from, 19 at the rate of percent per year. I (we)
hereby acknowledge and admit the validity and amount of that preexisting debt which the
principal sum stated in this note is intended to repay.

The note must be printed back to back.

2. Installments - This note is to be paid in monthly installments payable at (Insert
Name and Address of Contractor), on or before the day of the month) beginning on
, 19, and continuing until either the principal sum and all interest and
other charges assessed under the provisions of this note have been fully paid, or this note is
considered to be in default. The monthly installment amounts shall be not less than
dollars beginning on, and not less than
lollars beginning on

- **3.** Administrative Charges Administrative charges to cover the costs incurred by the United States in handling and processing past due amounts will be assessed at the rate of \$5.00 for each payment more than 30 days past due; an additional \$12.00 for each payment more than 60 days past due; and an additional \$15.00 for each payment more than 90 days past due.
- **4.** Late Payment Penalties Late payment penalties will be assessed on any amounts more than 90 days past due, at the rate of six percent per year.
- **5.** Payment Crediting The payments that I (we) make under this note will be credited as of the date received by the (TRICARE Contractor Name), first to outstanding penalties and administrative charges; second to accrued interest; and third to the outstanding principal sum. Any payments that I (we) made to the United States on this debt during the period from the date from which interest accrues under this note (as specified in paragraph 1) until the effective date of this note (as specified in paragraph 10.) shall be applied to the principal sum, interest, and other charges accruing under this note in accordance with the provisions of this paragraph.
- **6. Default, Acceleration, and Other Remedies** If any installment shall remain unpaid for a period of 30 days or more, this note shall at the option of the United States be considered to be in default. In the event of default, the full amount of the principal sum, together with any accrued interest and other charges assessed under this note, less any payments actually received by the United States from me (us), shall be due and payable in full immediately, without the need for further demands or notices to me (us). Furthermore, in that event, the United States may exercise any collection options legally available to it, including but not limited to, taking administrative offset, filing adverse credit reports to local and national credit bureaus, and referring my (our) account for legal action.
- **7. Default Costs and Fees** In the event of default, I (we) agree to pay all reasonable collection costs, court costs, and attorney's fees incurred by the United States as a result of the default and any appropriate collection actions taken by the United States.
- **8.** Controlling Law Except where controlled by Federal Law, all disputes concerning this note shall be controlled by the law of the jurisdiction in which I (we) reside at the time this note is signed.

FIGURE 11-A-12 PROMISSORY NOTE IN REPAYMENT OF PRE-EXISTING DEBT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

- **9.** Changes The provisions of this note may not be changed except by a written agreement which specifies the agreed upon changes and which is signed by both me (us) and an authorized representative of the United States.
- **10.** Legal Effect This note shall not be legally binding upon me (us) or the United States until it has been first signed by me (us).
- **11. Signatures and Certification** I (we), the maker(s) of this note, do hereby certify that I (we) have read and understood the terms of this note, and that all blank spaces above my (our) signature(s) in this note were filled in when I (we) signed it.

SIGNED:		
Maker's signature	Maker's name (printed)	Maker's address
Date		
Maker's signature	Maker's name (printed)	Maker's address
Date		
Maker's signature	Maker's name (printed)	Maker's address
Date		

FIGURE 11-A-13 COVER SHEET - CA	ASE RECOUPMENT	
At-Risk Not-At-Risk (circl	e one) R	CN or ICN:
Debtor's SSAN or TIN:		
Debtor Code Is: (B)Beneficiary; (P)I	Provider; (S)Sponsor; (O)Other
Debtor's Relationship to Sponsor C (4)Former Spouse; (5)Widow/Wido		se; (3)Natural/Adopted <mark>/Step</mark> Chilo
Debtor's Last Name:	First:	Middle Initial:
Debtor's Address Line 1:		
Debtor's Address Line 2:		
Debtor's Address Line 3:		
City:	State:	Zip Code:
Debtor's Telephone:		Ext.:
Contractor Number (Prime Contractor	ctor):	, Region:
Date Of Initial Demand Letter:	D	ate Debt Discovered:,
Reason For Overpayment: (Numeric Entry)		
Original Amount Of Debt:	(Offset Status:
Sponsor's Last Name:	First:	Middle Initial:
Sponsor's Address Line 1:		
Sponsor's Address Line 2:		
Sponsor's Address Line 3:		
City:		
Sponsor's Telephone:		Ext:
Sponsor's SSAN:		
Sponsor's Branch of Service Code Is (5)Coast Guard; (6)Public Health Se Administration (NOAA)		* · · · · · · · · · · · · · · · · · · ·
Beneficiary's Last Name:	First:	Middle Initial:
Beneficiary's Relationship to Spons (5)Former Spouse	or Code Is: (1)Self; (2)S	Spouse; (3)Child; (4)Other;
No. of Months Left Unpaid on Inst	allment Agreement: _	
Date Last Installment Payment Rec	eived:	
Scheduled Amount of Installment	Payment:	
Interest Rate:		
Principal Balance Due:	Principal Paid	to Date:
Interest Balance Due:	Interest Paid to	Date:
Interest Paid YTD:		
Due Date of Last Unpaid Installme	nt Payment:	

FIGURE 11-A-14 CODES TO BE USED WHEN COMPLETING THE COVER SHEETS (NOT-AT-RISK FUNDS INVOLVED)

CODE	INCORRECT PAYMENT
01	AUTHORIZATION/PREAUTH NEEDED
02	BENEFIT DETERMINATION WRONG/UNSUPPORTED
03	BILLED AMOUNT INCORRECT
04	COST-SHARE/DEDUCTIBLE ERROR
05	DEVELOPMENT CLAIMS DENIED PREMATURELY
06	DEVELOPMENT REQUIRED - NOT PERFORMED
07	DUPLICATE CLAIM PAID
08	ELIGIBILITY DETERMINATION - PATIENT
09	ELIGIBILITY DETERMINATION
10	MEDICAL EMERGENCY NOT SUBSTANTIATED
11	MEDICAL NECESSITY/REVIEW NOT EVIDENT
12	NONAVAILABILITY STATEMENT ERROR
13	OHI - GOV'T PAY MISCALCULATED
14	OHI PAYMENT NOT CALCULATED
15	PAYEE WRONG - SPONSOR/PATIENT
16	PAYEE WRONG - PROVIDER
17	PARTICIPATING/NON-PAR ERROR
18	PRICING INCORRECT
19	PROCEDURE CODE INCORRECT
20	SIGNATURE ERROR
21	TIMELY FILING ERROR
99	OTHER - SEE REMARKS

FIGURE 11-A-15 DELINQUENCY NOTICE (NOT-AT-RISK FUNDS INVOLVED)

(Addressee)
(Address)
(City, State, ZIP)
Account Receivable Number:
(Contractors may add any identifying information they deem necessary.)
Dear:
To date we have not received your payment for \$(Enter Amount Past Due) . Our records indicate that your account is (Enter Number) days delinquent.
In order to bring your account current and to avoid additional interest charges, administrative and penalty fees, please forward your check or money order in the amount of \$(Enter amount past due plus the amount of the next regular monthly installment) immediately.
As you have been previously advised, information regarding your delinquent account will be referred to a consumer reporting agency if your payment is not received within 30 calendar days of the date of this notice.
Additionally, if no response is received within 30 days from the date of this notice, your debt will be referred to the Office of General Counsel, TMA. Involuntary collection action will be initiated against you. Your debt may be collected by administrative offset from other federal monies you may be owed. Offset may be taken against your salary or retired pay under the authority of 37 U.S.C. 1007(c), or your federal income tax refund pursuant to the Debt Collection Act of 1982 and the Deficit Reduction Act of 1984. Your debt may be referred to a collection agency for collection or to the Department of Justice for litigation. If a judgment is obtained against you, execution upon that judgment may result in garnishment of wages and/or seizure and subsequent sale of your assets.
Your prompt attention to this matter will be appreciated.
Sincerely,
(Signature) (Title)

NOTE: These notices may be sent in duplicate, so that one copy may be returned with the debtor's next installment payment. Contractors who wish to vary the substance of the delinquency notice must contact the Chief, Recoupment Division, TMA, before doing so.

FIGURE 11-A-16 SAMPLE FINAL DEMAND LETTER (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 90 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

(<u>Addressee)</u>		
(Address)		
(City, State, ZIP)		
	DATE:	(Enter date mailed.)
	TIN:	(If debtor is the sponsor, enter sponsor's SSN. If debtor is not the sponsor, enter debtor's SSN, if known; unknown leave blank.)
	PRINCIPAL:	ŕ
	INTEREST:	(Enter interest on principal at current rate for 90 days.)
	TOTAL DUE:	•
Dear:		

On **(Date)** and **(Date)**, we wrote to you asking you to refund an erroneous payment. Enclosed are two copies of a Promissory Note providing for repayment of the debt in monthly installments of **\$(Enter a figure which will allow for repayment of the debt, with interest, within 2 years)**. Please sign and return one copy of the note; you will then be obligated to make monthly payments under the terms of the note.

Your first payment should be sent to arrive not later than (Enter a date 30 days after the date of this final demand letter). Send your checks or money orders, made payable to (TRICARE Contractor Name), directly to this address:

(Address of the Contractor)

As you have been previously advised, information regarding your delinquent account may be referred to a consumer reporting agency if the signed Promissory Note and your initial payment are not returned within 30 calendar days of the date of this letter. Additionally, your debt will be referred to the Office of General Counsel, TMA-Aurora. That office will initiate involuntary collection action against you. Your debt may be collected by administrative offset from other federal monies you may be owed. That may include offset against your salary or retired pay under the authority of 37 U.S.C. 1007(c), or your federal income tax refund pursuant to the Debt Collection Act of 1982 and the Deficit Reduction Act of 1984.

Your debt may be referred to a collection agency for collection or to the Department of Justice for litigation. If a judgment is obtained against you, execution upon that judgment may result in garnishment of wages and/or seizure and subsequent sale of your assets.

	Sincerely,
	(Signature) (Title)
Enclosures:	
Promissory Note	

FIGURE 11-A-17 EXAMPLE OF REPAYMENT AMORTIZATION (NOT-AT-RISK FUNDS INVOLVED)

NUMBER	INTEREST	AMORTIZED	BALANCE	ACCUM. INT	
Principal \$1000 At 8% For 0 Years 24 Months					
REGULAR PAYMENT = \$45.2243					
1	\$ 6.67	\$ 38.5543	\$ 961.446	\$ 6.67	
2	6.41	38.8143	922.631	13.08	
3	6.15	39.0743	883.557	19.23	
4	5.89	39.3343	844.223	25.12	
5	5.63	39.5943	804.628	30.75	
6	5.36	39.8643	764.764	36.11	
7	5.10	40.1243	724.64	41.21	
8	4.83	40.3943	684.245	46.04	
9	4.56	40.6643	643.581	50.60	
10	4.29	40.9343	602.647	54.89	
11	4.02	41.2043	561.442	58.91	
12	3.74	41.4843	519.958	62.65	
YR. 1	\$62.65	\$480.042			
1	\$3.47	\$41.7543	\$478.204	\$66.12	
2	3.19	42.0343	436.169	69.31	
3	2.91	42.3143	393.855	72.22	
4	2.63	42.5943	351.261	74.85	
5	2.34	42.8843	308.376	77.19	
6	2.06	43.1643	265.212	79.25	
7	1.77	43.4543	221.758	81.02	
8	1.48	43.7443	178.013	82.50	
9	1.19	44.0343	133.979	83.69	
10	0.89	44.3343	89.6448	84.58	
11	0.60	44.6243	45.0205	85.18	
12	0.30	45.0205	0.00	85.48	
LAST PAYMENT = \$45.32					
YR. 2	\$22.83	\$519.958			
DIFFERENCE IN TOTAL INTEREST PAID IS DUE TO ROUNDING-OFF					

FIGURE 11-A-18 LETTER TO BENEFICIARY WHOSE CLAIM WAS OFFSET AGAINST DEBT OWED BY PARTICIPATING PROVIDER (NOT-AT-RISK FUNDS INVOLVED)

(Addressee)		
(Address)		
(City, State, ZIP)		
	DATE: ICN:	(Enter date mailed.)
Dear:		
Enclosed is a copy of the Explan number. You will note that the TRIC been offset to collect a prior erroneo participate on your claim.	CARE allowable char	
The EOB satisfies the TRICARE participating provider has agreed to share as payment in full. Any attem amount in excess of the total of your would violate federal regulation and	accept the TRICAR pt by the provider or r cost-share, deducti	E payment, together with your cost f medical services to collect an ble, and any noncovered services
	Sincerely,	
	(Signature) (Title)	
Enclosure		

FIGURE 11-A-19 LETTER ESTABLISHING INSTALLMENT PAYMENT AGREEMENT WHEN THE DEBT DOES NOT EXCEED \$600.00 (NOT-AT-RISK FUNDS INVOLVED)

(A.11				
(Addressee)				
(Address) (City, State, ZIP)				
RE: Sponsor SSN: Patient: Claim Number: Accounts Receivable Number:				
(Contractors may include whatever in	dentifying information they deem necessary.)			
Dear:				
Since you indicated a desire to repay y monthly installments, this office will accept	rour debt of \$(Enter Principal Amount of Debt) in pot monthly payments of \$ Interest will be at the rate of (Enter Current Interest Rate) per year or).			
one month from the date the debtor requ	rrive not later than (Enter a date approximately ested an installment agreement). Send your (TRICARE Contractor Name), directly to:			
(Name and A	address of Contractor)			
You will receive a payment acknowledgm	est, and then to the outstanding principal balance. ent following receipt of each installment. The g balance and the amount of each installment that			
	pt payment will reduce your total interest orwarded to the Office of General Counsel, TMA-			
assure proper credit is given. Alternativel or each acknowledgment notice may be d	otor include whatever information is necessary to ly, the debtor may be furnished payment coupons luplicated, so that one copy may be returned with r may be asked to return a copy of this letter with			
Your cooperation in this matter is appr	reciated.			
	Sincerely,			
	(Signature) (Title)			

FIGURE 11-A-20 SAMPLE CALCULATION AND APPLICATION OF INTEREST (NOT-AT-RISK FUNDS INVOLVED)

Principal: \$1000.00 Interest Rate: 8%

Monthly Installment Amount: \$45.22 Initial Demand Letter Mailed: 01/05/2000

Debtor Requests Installment Repayment Agreement: 03/03/2000

Promissory Note Prepared by contractor on 03/05/2000; First Installment Due 04/05/2000 (or it may be 04/01/2000, if the contractor chooses to have all installment payments due on the first of each month). For purposes of this example, it is assumed that the due date is 04/05/2000.

1. Debtor's first payment of \$45.22 received 04/03/2000.

Interest on \$1000 from 01/05/2000 until 04/03/2000: Interest = Number of days since last computation of interest (or date interest began to accrue) x daily rate x principal balance.

88 days x .0002191 $(1/365 \times .08) \times $1000 = 19.29

Monthly Installment Payment (\$45.22) less Interest (\$19.29) = \$25.93 (apply to principal balance). New principal balance is \$974.07. Payment acknowledgment notice issued. Next installment of \$45.22 is due 05/05/2000.

2. (Debtor's second payment of \$50.00 received 05/07/2000.)

Interest on \$974.07 from 04/03/2000 until 05/07/2000:

34 days x .0002191 (daily interest rate calculated above) x \$974.07 = \$7.26

Monthly Payment (\$50.00) less Interest (\$7.26) = \$42.74 (apply to principal balance). New principal balance is \$931.33. Payment acknowledgment notice issued. Debtor paid the 05/05/2000 installment, plus \$4.78 toward the 06/05/2000 installment.

3. Delinquency notice issued 07/10/2001 (35 days after due date).

Debtor's third payment of \$40.00 received 07/12/2001.

Interest on \$931.33 from 05/07/1990 until 07/12/2001:

66 days x .0002191 (daily interest rate) x \$931.33 = \$13.47

Monthly Payment (\$40.00) less Interest (\$13.47) = \$26.53 (apply to principal balance). New principal balance is \$904.80. Payment acknowledgment notice is issued. Debtor paid \$40.00 toward the 06/05/2000 installment. He owes 44 cents on the 06/05/2000 installment and \$45.22 on the 07/05/2000 installment. Debtor must be advised that in order to bring his account current, he must remit \$45.66 to cover the balance due on the June installment and the entire July installment. Since the account is not delinquent by two installments (\$45.22 x 2) the case is not referred to TMA.

Commercial computer programs are available which will calculate interest daily on the unpaid principal balance in the manner reflected above. A variation of a few cents may be noted due to rounding.

FIGURE 11-A-21 SAMPLE PAYMENT ACKNOWLEDGMENT (NOT-AT-RISK FUNDS INVOLVED)

Thank you for your installment payment in the amount of \$45.22, which was received April 3, 2000. This payment has been applied as follows toward repayment of your indebtedness to TRICARE:

INTEREST CHARGES: \$19.29

PRINCIPAL: \$25.93

YOUR REMAINING PRINCIPAL BALANCE IS: \$974.07

YOUR NEXT INSTALLMENT PAYMENT IS DUE 05/05/2000.

This information may be useful in the preparation of your income tax return.

These acknowledgments may be typed, or computer-generated. They should include the debtor's name and address and the contractor's account receivable number. They may be sent in duplicate, so that one copy may be returned with the debtor's next installment payment to assist the contractor in identification of the payment. The total interest paid for the calendar year may be added. Contractors who wish to vary the substance of the acknowledgment notice must contact the Chief, Recoupment Division, TMA, before doing so.)

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED)

U.S. Department of Justice

Financial Statement of Debtor (Submitted for Government Action on Claims Due the United States) (NOTE: Use additional sheets where space on this form is insufficient or continue on reverse side of pages.)

Authority for the solicitation of the requested information is one or more of the following: 5 U.S.C. 301, 901 (see Note, Executive Order 6166, June 10, 1933); 28 U.S.C. 501, et seq

Authority for the solicitation of the requester minoritation is one or more of the following: 9 U.S. 31 U.S.C. 501, et seq. 44 U.S.C. 3010; 4 CFR 101, et seq. 28 CFR 0.160, 0.171 and Appendix to Subpart Y.

The principal purpose for gathering this information is to evaluate your capacity to pay the Government's claim or judgment against you. Routine uses of the information a established in the following U.S. Department of Justice Case File Systems published in Vol. 42 of the Federal Register, Justice/TO-001 at page 53321, Justice/TAX-001 at page 15340, Justice/XA-005 at pages 53406-5340, Justice/XBA-005 at pages 153406-53410, Justice/XBM-016 at page 15740. Disclosure of the information is voluntary. If the requests information is not furnished, the U.S. Department of Justice has the right to such disclosure of the information by legal methods.

Your Social Security account number is helpful for identification, but you are not required to indicate it if you do not desire to do so.

1.	What is your:						
	a) Full legal name						
	o) Other names you have ever used						
	c) Date of birth						
	d) Social Security Number						
	e) Driver Licence No						
	Issued by state of						
	f) Residence Address						
	(but de City Chate 9.7% Co.d.)						
	(Include City, State, & Zip Code)						
	g) Residence telephone ()						
	h) Business address						
	(Include City, State, & Zip Code)						
	Business telephone ()						
2.	Employment:						
9	a) Full name of current employer						
·	b) Employer address						
	(Include City, State, & Zip Code)						
	c) Employers telephone No. ()						
	d) How long have you worked there?						
	e) Job title						
) Monthly take-home pay(Do <u>Not</u> deduct savings-account deposits, etc.)						
	Monthly Monthly Monthly Salary (wages): Commissions: Other: Total:						

FORM OBD-500

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

g)) What is your yearly gross income?				
h)	What was your annual net income last year? What was the source of your income last year?				
i)					
 j) 	Last employer's Name and Address?				
	(City, State, & Zip Code)				
	Length of employment				
k)	If you are self-employed, what is:				
	Your business licence No.				
	Where are you licenced?				
	Name of business				
	Type of business				
•	Address of business				
	Telephone of business				
	Do you own all of the business (yes) or (no) If no, state:				
	Date you acquired your interest				
	Present value of your interest				
	Percentage of total your interest represents				
	How and when do you draw or receive money from such business?				
	Your office or position				
	Full name and address of each officer and director or partner, or other part owner.				

	Name		Addr	ess	
	Name _		Addr	ess	
	Name _		Addr	ess	
		bank or other account, state		nich the business	maintains any
	of Instit	and address tution	Type of Account	Name on Account	Average Daily Balance
3				hin au contificato	of doing business
3.	under an a	issumed name amed above, s	were filed with	any government	of doing business agency by any
	(a) Nature	of document f	iled		
	(b) Locatio	n of office whe	ere filed		
	(c) Date of	filing			
4.	If your spo employed,	use (husband/ , then state:	wife), children o	or relatives living	with you are
Full <u>Nam</u> e		Relation to you	Full name and o	complete address	of employer
5.	Date last T	 ax Returned Fi	iled	INCLUDE A COP	Y OF YOUR FEDERAL & STATE
	Single		Joint		
	Gross Inco	me reported \$			
6.				om whom, appro	

FINANCIAL DATA

(List all bills or loans that are paid on a monthly basis)					
	MONTHLY	TO WHOM PAID	BALANCE DUE		
Rent:					
Mortgage:					
Taxes & Insurance:			12 6		
Food:					
Laundry:					
Gasoline:					
Babysitter:					
Gas & Electric:					
Phone:		-	***************************************		
Cable TV:			4		
Water:			-		
Sewer:			***		
Trash pickup:					
Insurance: auto:					
health:		*			
life:					
property (if included in Mortgage so state):					
Drugs:		*****			
Medical/Dental:					
Child Support:		***************************************			
Alimony:					

INSIA	ALLMEN	<u>TS</u>			
			MONTHLY PAYMENT	TO WHOM PAID	BALANCE DUE
Car:				-	
Credi	t Cards:				
				-	
Other bu	· loans: isiness, e	(personal, etc.)			
Othe	month	ly			
pa	yments				
Any o	ther del u owe?	bts			
Judgr	nents yo	ou owe?			
8.				ASSETS	
A)	Che	cking Account	5:		
	a)	Bank name:			
		Bank branch):		
		Account Nu	mber:		
		In name of:			
B)	Sav	ings Account:			
	a)	Bank name:			
		Bank branch):		

C)	Stocks and Bonds, Certificate of Deposits, or other securities:					
	With whom:					
	Account Number:					
	Value:					
	Pension:					
	Profit Sharing:					
D) If you, your spou motor vehicle, tr vehicle of any so		, motorcycle, air	of your family livi craft, boat or oth	ing with you have a and the recreational		
		1st Vehicle	2nd Vehicle	3rd Vehicle		
Year						
Make						
Model						
License N	lo.					
Motor N	0.					
Registrat (aircraft/	tion No. boats)					
Serial No) .					
State						
Est. Value						
Lienholder						
Amt Owed			•			
Title in Name of						
Present Location						

Usual Location	-		
E) If yo	ou own any firearms, the	n state:	
Make and Mc	odel <u>Serial Nu</u>	mber	Exact Present Location
			
F) If yo	ou own any Antiques of a	any kind state:	
Description	Approximat	e Value	Exact Present Location
G) If yo	ou own any Jewelry/Gold	 l/Silver, state:	
Description	Approximat	e Value	Exact Present Location
H) If ye	ou own any VCRs. Satelli	 te Antennas. T\	/s, Stereos, Compact Discs,
Con	nputers, Musical Instrum	ents, state:	, , , , , , , , , , , , , , , , , , , ,
Description	Approximate Value	Serial No.	Location

·····			

i)	If you own any any kind, state	furniture/Appliance :	es (such as	stove, re	frigerator, etc.)	of .
Descript	<u>ion</u>	Approximate Value	2	Location		
			-		·	Ĉ
			-			
			-			
١)	If you own any	collections of any k				ate:
<u>Descript</u>	ion	Contents	Estimated Present Market V		Exact Present Location	
K)	•	tools or equipment	_			
Complet Descript of each	ion	Reg. No. Serial No.	Estimated Present Value	Prese Locat		
						

L) If you own	n any sporting good	ds or equipment, s	tate:	
Complete Description of each Piece	Reg. No. Serial No.	Estimated Present Value	Present Location	
M) If you own	n any paintings or c	other art objects of	any kind, st	tate:
Complete Description of each Piece	Reg. No. Serial No.	Estimated Present Value	Present Location	
-	e any other person			
Description of each item		Estimated Value	Present Location	
O) Real Estat	re (include Personal			
Type	Rent/Own	Address of Proper		<u>lienholder</u>

P) Other Assets-List, i.e.: Season tickets, Symphony, etc.			ootball, Baseball, Basketball,		
Descrip	otion Appr	oximate Value	Present Locat	tion	
Q)	If any item of your pro	operty has been ple	edged to secure a	debt, state:	
(a)	Description of property pledged	Item 1	Item 2		
(b)	Amount of debt secur	ed			
(c)	How debt was incurre	d	·		
(d)	Date on which debt w incurred	as			
(e)	Name and address of pledgee:				
Name a	and Address				
Name a	and Address				
(f)	Date on which possess transferred to pledgee			1480	
9.	Debts owed to you by				
Name	<u>Address</u>	Type of debt owed	Monthly payment	Balance due	

10.	Are you a party in a lawsuit? (Explain)	n)
11.	Are you a trustee, Executor, or Admin	nistrator? (Explain)
12.	Do you hold a Power of Attorney for s	someone? (Explain)
13.	Is anyone holding any money or prop (Yes or No) (Explain-include name, ad	perty on your behalf? ddress, and phone number)
Code that th Depar is a co	knowledge of the penalties for false state 1001 (\$10,000.00 fine and/or five years im his financial statement is submitted by me tment of Justice. I certify that I believe th mplete statement of all my income and as name or by any other.	nprisonment) and with knowledge e to affect action by the U.S. ne above statement is true and that it
	Date	Signature

FIGURE 11-A-23 LETTER ESTABLISHING INSTALLMENT REPAYMENT AGREEMENT WHEN DEBT EXCEEDS \$600.00 (NOT-AT-RISK FUNDS INVOLVED)

(RE:	Sponsor SSN: Patient: Claim Number Accounts Receivable Number:
((Contractors may include whatever identifying information they deem necessary.)
Dear _	
copies your i	nce you indicated a desire to repay your debt in monthly installments, enclosed are two s of a Promissory Note in the amount of \$(Enter Principal Amount of Debt) outlining repayment schedule. The note requires payment of interest at (Enter Current Interest per year from (Enter Date of Initial Demand Letter) with monthly installments of .
Your f	e sign and date the Promissory Note and return one copy to (Address of Contractor). first payment should be sent to arrive not later than (Enter a date approximately one h from the date the debtor requested an installment agreement). Send your checks or y orders, made payable to (TRICARE Contractor Name) directly to:
	(Address Of Contractor)
You wackno	hyments will be applied first to interest, and then to the outstanding principal balance. Will receive a payment acknowledgment following receipt of each installment. The owledgment will reflect the remaining balance and the amount of each installment that pplied to principal and to interest.
assess	nce interest is calculated daily, prompt payment will reduce your total interest sment and allow you to avoid additional late charges. Delinquent accounts will be orded to the Office of General Counsel, TMA, for involuntary collection action.
or eac	Contractors may request that the debtor include whatever information is necessary to e proper credit is given. Alternatively, the debtor may be furnished payment coupons the acknowledgment notice may be duplicated, so that one copy may be returned with ext installment payment. The debtor may be asked to return a copy of this letter with er first installment.)
Yo	our cooperation in this matter is appreciated.
	Sincerely,
	(Signature) (Title)
Enclo	sure

FIGURE 11-A-24 FINANCIAL AFFIDAVIT TRANSMITTAL LETTER (NOT-AT-RISK FUNDS INVOLVED)

	essee)	
(City,	State, ZIP)	
RE:	Sponsor SSN: Patient: Claim Number Accounts Receivable Number:	
(C	Contractors may include whatev	ver identifying information they deem necessary.)
Dear _	:	
\$Statem address Gener	would result in a financia nent of Debtor. Please complete ssed envelope. The completed fi	nt of your debt to TRICARE in the amount of al hardship for you, enclosed for your use is a Financial the form and return it to this office in the enclosed, self- inancial statement will then be referred to the Office of tion of your request for relief from indebtedness. That
•	you do not complete and return tter, involuntary collection actio	the financial statement within 30 days from the date of on will be taken against you.
		Sincerely,
		(Signature) (Title)
Enclos	sures:	
	cial Statement of Debtor	
Self-ac	ddressed envelope	

FIGURE 11-A-25 LETTER ADVISING DEBTOR THAT HIS ACCOUNT HAS BEEN REFERRED TO TMA (NOT-AT-RISK FUNDS INVOLVED)

(Addressee) (Address) (City, State, ZIP)
Accounts Receivable Number:
(Contractors may include whatever identifying information they deem necessary.)
Dear:
Because (<i>indicate the reason for account referral to TMA</i> , <i>i.e.</i> , two full installment payments are past due on your account, <i>your account is delinquent</i> , <i>etc.</i>) your debt has been referred to TMA for involuntary collection action. All future payments should be sent to the following address:
Finance and Accounting Office TMA 16401 East Centretech Parkway Aurora, CO 80011-9066
Correspondence regarding your debt should be sent to the following address:
Recoupment Division Office of General Counsel TMA 16401 East Centretech Parkway Aurora, CO 80011-9066
Sincerely,
(Signature) (Title)

FIGURE 11-A-26 PROVIDER'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED)

WHEREAS the undersigned has filed claims as a participating provider under TRICARE on behalf of a TRICARE beneficiary, (Enter Name Of Beneficiary), (Sponsor's Name, Sponsor's SSN) who is entitled to benefits of TRICARE under applicable provisions of law and regulation and,

WHEREAS the TRICARE program is by law a secondary payor to all other insurance, medical insurance or health plans, to the extent that a particular service or supply is a benefit under such other plans and,

WHEREAS the TRICARE beneficiary is a beneficiary of another medical benefits plan provided through (Enter Name Of Primary Insurer) which has ceased honoring claims pursuant to (Enter Reason, i.e. Filing Petition In Bankruptcy, Having Been Placed In Receivership).

NOW THEREFORE, in consideration of TRICARE assuming a first-payor status on claims submitted on behalf of the above-named TRICARE beneficiary, the undersigned provider hereby assigns to the United States of America to the extent hereinafter indicated, all claims, demands, entitlements, judgments, administrative awards, and the proceeds thereof, and all causes of action which have been assigned by the beneficiary to the undersigned, and which the beneficiary may assign hereafter to the undersigned, by reason of any liability of third parties entitling the beneficiary to hospital care, or medical or surgical treatment, or to reimbursement for all or part of the cost of any such; or recovery of damages for all or part thereof:

- (a) based on contract, partially enumerated here as (1) membership in a union, fraternal or other organization; (2) rights under a group hospitalization plan or under any insurance, contract or plan which provides for payment or reimbursement for the cost of medical or hospital care, including "no fault" automobile insurance,
- (b) based on statute, State or Federal (other than P.L. 87-693, Stat. 593), and regulations promulgated pursuant thereto, partially enumerated here as (1) "worker's compensation" statutes; (2) "employer's liability" statutes; (3) right to "maintenance and cure" in admiralty.

The extent of this assignment is an amount equal to the total reasonable charges for hospital care, medical, surgical and clinical treatment, or any of them, including ambulance transportation and other auxiliary services provided the beneficiary by the undersigned. This assignment does not include any sums to which the undersigned is entitled on a fixed basis which do not depend upon the amount incurred or disbursed by the beneficiary for such care; (sometimes referred to in the insurance business as a right to indemnity).

The various provisions of this assignment are separable. The execution hereof is without prejudice to any lien in favor of the undersigned, on any such money, and any judgment, which the undersigned recovers, or is or becomes entitled to recover, which lien arises by virtue of statute, or of contract, including this contract, (which shall be construed as granting such a lien, and not as an election of waiver thereof); and the undersigned further agrees that any such rights are and shall be for the benefit of said United States of America to the extent of the reasonable charges for the care furnished the above-named beneficiary.

FIGURE 11-A-26 PROVIDER'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

The undersigned participating provider hereby irrevocably appoints the United States of America to do all acts, matters and things deemed necessary or desirable by it with full power and authority in the name of the undersigned provider, but at the cost, risk and charge, and for the sole benefit of said United States of America to sue for, or compromise, and to recover and receive all or part of the amount hereby assigned; and irrespective of assignment, to collect and disburse such funds in behalf of the undersigned; and to give releases for the same.

The POWER OF ATTORNEY AND AGREEMENT shall remain in effect until such time as the beneficiary is again fully covered by other insurance and any claims outstanding with **(Enter Name Of Primary Insurer)** have been fully resolved and settled or until voluntarily terminated by the United States of America.

DATED this	day of	, 19
		(Name of Participating Provider)
		(Signature of Provider or Authorized Agent)
Witness:		(Provider's Identification Number)

FIGURE 11-A-27 SAMPLE LETTER TO PROVIDER (NOT-AT-RISK FUNDS INVOLVED) (Enter Name And Address Of Provider) Patient: Sponsor: Sponsor: Sponsor's SSN: Enclosed is a Power of Attorney and Agreement. Federal statute makes TRICARE secondary payor to all other forms of health insurance. However, because (Enter Name Of TRICARE Beneficiary's Primary Health Insurer), (Enter Name of Primary Insurer), has filed a petition in bankruptcy (or has been placed in receivership), this office can process your claim for care provided to (Enter Name of TRICARE Beneficiary, Sponsor's Name, Sponsor's SSN) as primary payor only if you sign and return the enclosed form. Please return the signed Power of Attorney and Agreement in the enclosed, self-addressed envelope. If the signed Power of Attorney and Agreement is not returned to this

(If the contractor does not have documentation to prove that a claim was filed with the primary insurer or that a proof of claim was filed with the bankruptcy court, use the following paragraph.)

Please provide proof that you have filed a claim with the primary insurer or the bankruptcy court to obtain benefits from the primary insurance for the services in question.

Sincerely,
(Signature)

Enclosure

CC

(Enter Name and Address Of Beneficiary)

office within 10 days, your claim will be denied.

FIGURE 11-A-28 BENEFICIARY'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED)

WHEREAS the undersigned is a TRICARE beneficiary (**Sponsor's Name, Sponsor's SSN**) entitled to benefits of TRICARE under applicable provisions of law and regulation and,

WHEREAS the TRICARE program is by law a secondary payor to all other insurance, medical insurance or health plans, to the extent that a particular service or supply is a benefit under such other plans and,

WHEREAS, the undersigned is a beneficiary of another medical benefits plan provided through (Enter Name Of Primary Insurer), which has ceased honoring claims pursuant to (Enter Reason, i.e., filing a petition in bankruptcy, having been placed in receivership).

NOW THEREFORE, in consideration of TRICARE assuming a first-payor status on claims submitted by me, I hereby assign to the United States of America to the extent hereinafter indicated, all claims, demands, entitlements, judgments, administrative awards, and the proceeds thereof, and all causes of action which I now have, and which I may have hereafter, by reason of any liability of third parties entitling me to hospital care, or medical or surgical treatment, or to reimbursement for all or part of the cost of any such; or recovery of damages for all or part thereof:

- (a) based on contract, partially enumerated here as (1) membership in a union, fraternal or other organization; (2) rights under a group hospitalization plan or under any insurance, contract or plan which provides for payment or reimbursement for the cost of medical or hospital care, including "no fault" automobile insurance.
- (b) based on statute, State or Federal (other than P.L. 87-693, 76 Stat. 593), and regulations promulgated pursuant thereto, partially enumerated here as (1) "worker's compensation" statutes; (2) "employer's liability" statutes; (3) right to "maintenance and cure" in admiralty.

The extent of this assignment is an amount equal to the total reasonable charges for hospital care, medical, surgical and clinical treatment, or any of them, including ambulance transportation and other auxiliary services received by me. This assignment does not include any sums to which I am entitled on a fixed basis which do not depend upon the amount incurred or disbursed by me for such care; (sometimes referred to in the insurance business as a right to indemnity).

The various provisions of this assignment are separable. The execution hereof is without prejudice to any lien in favor of the party providing me hospital or other care, on any such money, and any judgement, which I recover, or am or become entitled to recover, which lien arises by virtue of statute, or of contract, including this contract, (which shall be construed as granting such a lien, and not as an election of waiver thereof); and I further agree that any such rights of mine are and shall be for the benefit of said United States of America to the extent of the reasonable charges for the care furnished me.

I hereby irrevocably appoint the United States of America to do all acts, matters and things deemed necessary or desirable by it with full power and authority in my name, but at the cost, risk and charge, and for the sole benefit of said United States of America to sue for, or compromise, and to recover and receive all or part of the amount hereby assigned; and irrespective of assignment, to collect and disburse such funds in my behalf; and to give releases for the same; but no such action shall limit or prejudice my right to recover for my own benefits all sums in excess of those amounts representing said reasonable charges for aid, care and treatment, or other sums to which I may be entitled.

FIGURE 11-A-28 BENEFICIARY'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

I hereby authorize the United States of America to disclose to said insurer, or other party against whom liability is asserted, or his or their attorneys, such information concerning me as the responsible representatives of the United States of America consider appropriate in connection with the subject matter hereof.

This POWER OF ATTORNEY AND AGREEMENT shall remain in effect until such time as I am again fully covered by other insurance and any claims outstanding with (Enter Name Of Primary Insurer) have been fully resolved and settled or until voluntarily terminated by the United States of America.

DATED this	_day of	, 19		
	(Signatur	e of Beneficiary)		
Witness:				
	(Beneficia	ary's SSN)		

FIGURE 11-A-29	SAMPLE LETTER TO BENEFICIARY (NOT-AT-RISK FUNDS INVOLVED)
(Enter Name And	l Address Of Beneficiary)
	Patient: Sponsor: Sponsor's SSN:
Dear	:
secondary payor health insurer, (En office can process	Power of Attorney and Agreement. Federal statute makes TRICARE to all other forms of health insurance. However, because your primary nter Name Of Primary Insurer), has filed a petition in bankruptcy, this your claim for care provided to (Enter Name Of TRICARE Beneficiary, Sponsor's SSN) as primary payor only if you sign and return the enclosed
addressed envelo	the signed Power of Attorney and Agreement in the enclosed, self- pe. If the signed Power of Attorney and Agreement is not returned to this ays, your claim will be denied.
	ctor does not have documentation to prove that a claim was filed with the or that a proof of claim was filed with the bankruptcy court, use the aph.)
	e proof that you have filed a claim with the primary insurer or the to obtain benefits from the primary insurance for the services in question.
	Sincerely,
	(Signature)
Enclosure	

FIGURE 11-A-30 BIANNUAL REPORT OF CLAIMS PAID BY TRICARE AS PRIMARY INSURER DUE TO OHI BANKRUPTCY/INSOLVENCY

BENEFICIARY	SPONSOR NAME	SPONSOR SSN	Provider	CLAIM #S PAID	AMOUNT PAID BY OHI (ASSETS DISTRIBUTED)	AMOUNT OF TRICARE OVER PAYMENT (IF ANY)	DATE RECOUPMENT INITIATED

FIGURE 11-A-31 PROVIDER BANKRUPTCY WORKSHEET

CLAIMS PENDED FOR PROVIDER BANKRUPTCY

Provider	
Provider Number	_
Provider TIN	_
Number of Claims Suspended	_
Value	_
Comments	

FIGURE 11-A-32 REFERRAL TO RECOUPMENT DIVISION, TMA

(Use Of this form is not mandatory)

	COLLECTIONS N	MADE BY O	FFSET/RE	FUND
	CTOR NUMBER:			ORT:
	? TIN:			
SPONSOR NAME	E:			
DATE REFERRED	O TO TMA:			
ORIGINAL AMO	UNT OF DEBT:			
BALANCE OF TIN	ME OF REFERRAL:			
	CURRENT PA	YMENT INFO	ORMATIO	N
DATE:	AMOUNT C	OF PAYMENT O	N CLAIM:	\$
PAYMENT HAS B	EEN RECEIVED THR	OUGH: OFFS	ET	REFUND
EXPLANATION:				
OFFSET INFORM	IATION:			
FORM COMPLET	TED BY:			